House of Representatives

File No. 808

General Assembly

January Session, 2017

(Reprint of File No. 230)

Substitute House Bill No. 7124
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 30, 2017

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR FERTILITY PRESERVATION FOR INSUREDS DIAGNOSED WITH CANCER.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-509 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after **[**October 1, 2005**]** January 1, 2018, shall provide coverage for the medically necessary expenses of the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. For purposes of this section, "infertility" means the condition of **[**a presumably healthy**]** an

individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

(b) Such policy may:

(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;

(2) Limit such coverage for ovulation induction to a lifetime maximum benefit of four cycles;

(3) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of three cycles;

(4) Limit lifetime benefits to a maximum of two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one cycle;

(5) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful;

(6) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;

(7) Limit coverage to individuals who have maintained coverage

under such policy for at least twelve months; and

(8) Require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner.

(c) (1) Any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

(d) Any health insurance policy issued pursuant to subsection (c) of this section shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

(e) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.

Sec. 2. Section 38a-536 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2018*):

(a) Subject to the limitations set forth in subsection (b) of this section

and except as provided in subsection (c) of this section, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after **[**October 1, 2005**]** January 1, 2018, shall provide coverage for the medically necessary expenses of the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. For purposes of this section, "infertility" means the condition of **[**a presumably healthy**]** an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

(b) Such policy may:

(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;

(2) Limit such coverage for ovulation induction to a lifetime maximum benefit of four cycles;

(3) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of three cycles;

(4) Limit lifetime benefits to a maximum of two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one cycle;

(5) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under

such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful;

(6) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;

(7) Limit coverage to individuals who have maintained coverage under such policy for at least twelve months; and

(8) Require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner.

(c) (1) Any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious employer a group health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

(d) Any health insurance policy issued pursuant to subsection (c) of this section shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are

excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

(e) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2018*	38a-509
Sec. 2	*January 1, 2018*	38a-536

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 18 $	FY 19 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Plan)	GF&TF -Potential Cost	See Below	See Below

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 18 $	FY 19 $
Various Municipalities	STATE MANDATE - Cost	See Below	See Below

Explanation

The bill will result in a potential cost to the state employee and retiree health plan and fully insured municipal plans[1], to the extent covered individuals who are ineligible for infertility services required by CGS §38a-509 are able to receive infertility services in accordance with the bill. In addition to coverage limits, current law limits eligibility to "presumably healthy" individuals; the bill removes this exclusion.

The impact will depend on (1) the utilization of services by individuals who have a diagnosis which would have precluded them from coverage under current law, and (2) the type of services utilized. For the most recent 12 month period, the state plan paid

[1] Pursuant to federal law self-insured health plans are exempt from state health mandates. The state plan is self-insured; however, the plan has historically adopted all state health mandates.

approximately $6.9 million for infertility services, inclusive of delivery and NICU costs directly related to infertility services ($3.9 million for infertility services and $3 million for related services). The state plan currently covers approximately 44,000 individuals between the ages of 18 to 39, the prime fertility age range. The National Survey of Family Growth[2] reports 12.3% of females (which represent approximately 52% of the state plan's population for the aforementioned age cohort) present with infertility issues and 11.3% utilize infertility services.

The impact to fully insured municipal plans will be reflected in premiums for policies renewed for the period including January 1, 2018.

For the purposes of the federal Affordable Care Act, the bill is not interpreted to be a new mandate and therefore the state will not be required to defray the cost of coverage for individuals in exchange plans.

House "A" struck the underlying bill and its associated fiscal impact and result in the fiscal impact described herein.

The Out Years

The cost reflected above will continue into the out years subject to the utilization of services by covered members of the state employee and retiree health plan who otherwise would not be covered under current law. The cost to fully insured municipalities will be reflected in the plans' premiums.

[2] *National Survey of Family Growth*, National Center for Health Statistics (Centers for Disease Control); survey data for the period 2011-2013.

OLR Bill Analysis

sHB 7124 (as amended by House "A")*

AN ACT CONCERNING MAXIMUM ALLOWABLE COST LISTS AND DISCLOSURES BY PHARMACY BENEFITS MANAGERS, LIMITING COST-SHARING FOR PRESCRIPTION DRUGS AND SHIELDING PHARMACISTS AND PHARMACIES FROM CERTAIN PENALTIES.

SUMMARY

This bill expands the range of people eligible for infertility coverage under certain individual and group health insurance policies.

By law, these policies must cover the medically necessary costs of diagnosing and treating infertility. Through its definition of "infertility," current law limits coverage to those who are presumably healthy and unable to conceive, produce conception, or sustain a successful pregnancy during a one-year period. The bill removes the "presumably healthy" limitation, thus extending infertility coverage to those who are not healthy. It appears also to extend coverage to anyone who requires medically necessary infertility treatment regardless of a time period.

The bill applies to policies delivered, issued, renewed, amended, or continued in Connecticut on and after January 1, 2018 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

The law, unchanged by the bill, allows (1) insurers to impose certain specified limits on infertility coverage and (2) religious employers and individuals to exclude infertility coverage from their policies if it is

contrary to their religious tenets.

*House Amendment "A" replaces the underlying bill, which (1) established requirements for a pharmacy benefit manager's use of maximum allowable cost lists, (2) limited out-of-pocket expenses for certain prescription drugs, and (3) prohibited health carriers from penalizing pharmacies and pharmacists for disclosing certain information to insured people.

EFFECTIVE DATE: January 1, 2018

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 1 (03/09/2017)